AMERICAN INTELLIGENCE.

ORIGINAL COMMUNICATIONS.

Sub-peritoneal Fibroid Tumour removed by Abdominal Section. By C. B. King, M.D., of Allegheny, Penna.

Catharine O——, æt. 36 years, a native of Switzerland, was admitted to the Western Pennsylvania Hospital May 13, 1876. She has always enjoyed good health until the present trouble began. First menstruated at eighteen years of age, and has been regular ever since. Was married at twenty-five, and is the mother of two children, the oldest ten years of age, and the youngest four years. Has never miscarried. Immediately after the last confinement, four years ago, she noticed a lump in her left side, but paid no attention to it, as it gave her no pain or inconvenience. On July 26, 1874, during a severe storm, the locality in which she lived (Butcher's Run) was flooded, and she was much frightened, as she was compelled to stand up to her waist in the water for some time. She is not aware of receiving any injury at the time, but shortly afterwards her abdomen began to enlarge, and slowly increased to such an extent as to seriously interfere with respiration and locomotion. On the tenth of last April she was visited by Drs. McCann, Smith, and myself, when we drew off about fourteen quarts of fluid, which relieved her very much. The fluid was albuminous, did not coagulate on exposure to air, and contained no ovarian cells. When admitted to the hospital, the abdomen was considerably distended with fluid. The uterus could be plainly felt above the pubes very much enlarged. In the left side was a tumour about the size of a child's head. It was hard, and could be easily moved about in the abdominal cavity, but appeared to move independently of the uterus. The uterine sound entered 6¼ inches, but the uterus remained fixed; evidently bound down by adhesions. There was considerable œdema of the lower extremities. The urine was normal but scanty, and passed with some difficulty. As she had been compelled to remain in bed for the last five months with insufficient food, she was very anæmic. Her appetite was poor, menstrual flow regular and of normal quantity, except upon two occasions when she lost large quantities of blood. She was put upon iron, quinia, and strychina.

May 21. Pulse 89; temp. 98¾°. Stomach rejects food, owing to enormous distention of abdomen. She was again tapped, and fourteen quarts of fluid withdrawn, which gave relief and enabled her to retain nourishment.

June 13. Pulse 90; temp. 99½°. Tongue clean; suffers no pain, but much inconvenience in breathing, from enormous distention of abdomen. Abdominal veins very much enlarged. The abdominal swelling is symmetrical, and measures as follows:—

	Inches.
Girth of body at ensiform cartilage	39½
Midway between umbilicus and ensiform cartilage	40½
At the umbilicus	43
Midway between umbilicus and pubes.	41¾
At the pubes	36
From umbilicus to each anterior spinous process	12
From symphysis pubis to umbilicus	20½
From umbilicus to ensiform cartilage.	9½

The patient being etherized, an incision was made in the median line, beginning about two inches below the umbilicus, and extending five inches in the median line. There being very little bleeding, I cut rapidly down on the peritoneum, which I incised, and drew off seventeen quarts of straw-coloured fluid. On opening the abdominal cavity, the ovaries were found to be normal. A large quantity of serum was sponged out which was highly coloured with blood from tearing up of recent adhesions between the uterus and abdominal wall. On the left side, just above the uterus, was found a fibroid tumour with a short and narrow pedicle attached to the fundus of the uterus. The pedicle was ¼ inch long by ¾ inch broad. Over the tumour were thickly spread enlarged veins, and these, collected into a plexus, were traced to the concavity of the liver, and were probably mesenteric in origin. The largest was ¼ inch in thickness. The tumour was slightly oval in shape, and about as large as a good-sized child's head at birth. The uterus was enlarged to the size of a double fist, and at one point behind, and to the right of the fundus, a protrusion could be felt, but no distinct fibroid could be defined.

There was no attachment between the uterus and abdominal viscera, but the uterus was bound to the anterior wall of the abdomen by adhesions which appeared to be recent, and bled freely when torn up. The tumour was separated from the uterus by the wire-rope ecraseur; no bleeding from the stump. The plexus of veins, which were about the thickness of two fingers, only slightly held together by connective tissue and looked like a bundle of earth-worms, were then gently drawn out, and Atlee's clamp applied five inches from the tumour. One large vein, which came from the opposite side of the intestine, was separated from the clamp and brought out near it to avoid constricting the bowel as the plexus shrivelled up. The peritoneum was noticed to be of a deep red colour around the attachment of the uterus to the abdominal wall. There was considerable delay in securing a complete removal of serum and blood from the abdomen. The wound was closed with silver wire, the clamp being fixed at upper part of incision. The cut end of pedicle, which was not included very tightly in the clamp for fear of cutting through the attenuated vessels, was touched with persulphate of iron, and the usual dressings after removal of ovarian tumour were applied. The operation lasted one hour. The patient was ordered two drachms of solution of morphia, and beef-tea, as soon as her stomach would bear it, and to be catheterized every three hours.

I visited her in the evening, six hours after operation, and found her resting comfortably; no pain; pulse 90; temp. 99⅜°.

14th, 9 A. M. Pulse 102; temp. 99½°; takes beef-tea well; slept four hours during night; suffers no pain.

15th, 9 A. M. Pulse 100; temp. 99½°; had severe pain yesterday afternoon, which lasted about five minutes, and was relieved by the passage of gas; is cheerful, and slept some during the night.

16th, 9 A. M. Pulse 84 ; temp. 98¼° ; slept from 9 P. M. to 3 A. M. ; dressings were changed, as the cotton was soiled by oozing of serum through the incision ; wound looks well ; no pain ; takes beef-tea freely.

17th, 9 A. M. Pulse 79 ; temp. 100° ; slept well all night ; no pain or tenderness over abdomen ; says she is hungry, and wants solid food ; wound looks well, and has united throughout whole extent.

20th. Pulse 72 ; temp. 98¼° ; rests well at night, and is free from pain ; all stitches, but one, removed.

22d. Pulse 72 ; temp. 98° ; last stitch removed ; clamp and ligature came away ; pedicle dressed with powdered oxide of zinc.

24th. Pulse 70 ; temp. 98° ; bowels moved by olive oil ; sits up in bed, and ordered solid food ; prescribed five grs. citrate of quinia and iron, three times a day.

July 7. Has been walking about the ward since 2d inst. ; sound enters uterus five inches ; discharged cured.

Aug. 2. Patient walked two miles to my office to-day, and says she is as strong as ever. There is no return of ascites.

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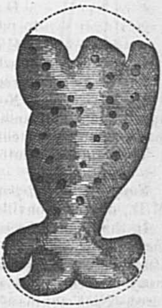
Case in which an India-rubber Nursing-tube was Swallowed by an Infant. By James Bordley, M.D., of Centreville, Md.

The following case appears to me as one of sufficient novelty to warrant its being recorded.

The accompanying wood-cut fairly represents the size, etc., of a rubber-nursing tube swallowed by an infant 18 months old, and passed per rectum, after remaining in the bowels for a period of ninety days, producing no symptoms worthy of note until four days prior to its expulsion (November 16th, 1875), at which time complete and obstinate obstruction of the bowels came on, with all the acute phenomena so characteristic of such trouble.



Although the child was watched with all that jealous care so characteristic of a fond mother and two grandmothers, no suspicion of the accident was entertained, and until the tube was evacuated it was never remotely thought of. But afterward the circumstances connected with its disappearance were recalled, and the date of its entry into the child's stomach could be fixed. One point at least of interest is the fact of the long retention of the tube without producing any ill effect ; no symptoms of obstruction manifesting themselves until four days prior to its discharge.

After considering the question from every point, the only theory offering a satisfactory solution appears to me to be, that the tube, being too large at either extremity to enter the ileo-cæcal valve, was retained about that point until the action of the fluids destroyed the rounded point or mouth, thereby rendering it more compressible, when it was so changed in form that it passed the constricted point, for it was there that the obstruction existed.

The following description will serve as an explanation of the drawing : As may be readily seen from the cut, the tube as expelled differed considerably in form, size, etc., from its original. Its density and flexibility were also greatly altered. From a soft, smooth, and elastic tube it became a hard, rough, and nearly inelastic mass.

The parts marked out by the dotted lines represent the portion destroyed by the digestive fluids, and the dark spots upon it represent the general appearance of its surface, studded, as it were, with small but hard and rough tubercles.

The length of the tube was 2 inches; largest circumference $2\frac{3}{4}$ inches.

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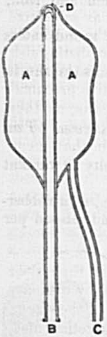
Description of an Improved Barnes's Dilator. By T. P. SEELEY, M.D., of Chicago, Illinois.

I have recently devised an improvement of Barnes's dilator, which all who have seen think well of, and which in actual practice has proved its usefulness.



A A represents a section of the dilator, which I have had made of two sizes, the larger of which is about two inches in width by three in length when not filled, the acuminate end being adapted for introduction into the cavity.

B is a tube passing longitudinally through the centre of the dilator, and attached to the distal extremity. Its object is to allow the entrance of a sound or director, by means of which the instrument is to be introduced into the uterus or rectum. It also serves to prevent the longitudinal extension, and thus increases the force of the lateral expansion of the dilator.

D represents a metallic socket at the end of the tube, to prevent perforation by the director.

C is a smaller tube connected with the dilator proper, by which it is to be distended with air or water after its introduction.

None who have used the Barnes's dilator will fail to appreciate the advantage of an improvement which renders quite easy its introduction and retention as long as may be required.

The improved dilators may be obtained of E. H. Sargent, of this city.

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Supplemental Report of a Case of Ovariotomy. By JAMES P. ORR, M.D., of Andersonville, Indiana.

In the report of a case of successful ovariotomy (*American Journal of the Medical Sciences*, July, 1876, page 291), I conclude by stating, that after four successive hemorrhages, from a small abdominal opening, at as many consecutive menstrual periods, the patient reported herself entirely cured. Nine months after the operation I was consulted about a sore spot at the lower end of the original incision, and at the point at which I had made the second incision for the purpose of cleansing the abdominal cavity on the supervention of septicæmic symptoms. On making an incision at this point through the integument, and a thin layer of other tissues, I discovered the Chinese silk ligature with which I had tied the pedicle of the tumour, then ten months previous. I removed this silk; found it almost as perfect as when it had been applied; and now, two months and nine days since the last operation, I find, by personal observation, the entire incision completely healed, and the patient increased 35 pounds in weight since the original operation.

Circulation of the Blood Subjectively Seen. By C. A. White, M.D., of Washington, D. C.

Sitting with the eyes completely closed, but usually better if facing the light, and looking intently as if to catch a glimpse of some object in the dark, one may perceive an appearance similar to that of the circulation of blood in the web of a frog's foot as seen under a magnifying power of, say, 100 diameters. The apparent capillary streams thus perceived in the eye are very numerous, but they are less definite and continuous than are those which we see in the frog's foot. The course of each also is irregular, and they seem to have no common direction, and are often much confused.

This phenomenon may be more distinctly observed if there be headache or other cerebral excitement, and I am disposed to regard it as subjective vision of the circulation of the blood in the choroid. I use the word subjective, not to imply that it is an "optical illusion," but to distinguish the phenomenon from ordinary objective vision, regarding it as the result of mechanical impingement of the blood-corpuscles against the proximal ends of the rods that compose the bacillary layer of the retina, as they rush against them in the capillaries of the membrane of Ruysch. The peculiar reticulated distribution of the abundant capillaries in that membrane accords well with the appearance as of capillary streams to be observed in the eye, as just explained.

That the appearance of light, and even of an object, may be produced by mechanical pressure upon the retina, is shown by the well-known "phosphène" perceived when the finger is pressed against the side of the eye. It is true that the apparent size of the corpuscles, assumed to be subjectively seen by this observation, is many times greater than their actual size; but then the retinal image of every object seen by ordinary vision is exceedingly small as compared with our conception of the size of the object. In the case of mechanical pressure against the retina also, the size of the phosphène perceived is always much larger than the part of the retina affected, and it is about the same size whether the finger-end or the head of a pin be used in producing it.

Autopsy of the Body of J. W. Wilkie, M.D., late Superintendent of the Auburn Asylum for Insane Convicts, as reported to his successor, C. T. McDonald, M.D. By D. Dimon, M.D.

The congenital abnormal condition of the right ventricle of the heart and aorta may give this report sufficient importance for publication.

The lungs were strongly adherent to the dorsal vertebra, the adhesions extending some distance from the vertebra along the ribs. The anterior surfaces of the vertebra were in numerous places rough, being denuded of the periosteum. The aorta from its base to beyond the arch was not less than three times its usual calibre, and its walls throughout of proportional thickness. The walls of the right ventricle were uniformly less than two lines in thickness, the heart, in other respects, natural. The muscular fibres were easily separated, but this defective tenacity was that of the tissues generally. The reversed condition of the right ventricle of the heart and the aorta could not be the effect of disease, but of a congenital displacement of the vessel formation of the right ventricle into the aorta.

The pulsations of the radial artery in a peculiar manner indicated the lack of the contractile force of the right ventricle when the doctor was in his usual health, and was not changed during his sickness. It had a full pulsation, followed by one or two slight short ones; as if the unequal pulsations were made by the left ventricle drawing on the pulmonary capillaries now full, now not so full, instead of being uniformly filled by the equal action of the ventricles on the aortic and pulmonary columns of blood.

For more than six months previous to his dissolution he had suffered excruciating pains along the dorsal vertebra, from which he only found relief by a repetition of blisters. From first to last he experienced no disturbance of the functions of the heart and lungs. At intervals of ease he attended to his usual duties about the asylum, and in going up and down flights of stairs he noticed no increased frequency of respiration or of the pulsations of the heart. This he observed himself was evidence that there could be no serious organic change in that organ. The only effect of its abnormal constitution was to diminish the force as indicated by the unequal contractions on the whole circulation to the extent of the defect in the right ventricle supported by the pericardium, somewhat contracted over the right side of the heart. This diminution of pressure on the circulation was not sufficient to cause any perceptible inconvenience from ordinary physical efforts, and the doctor's vocation and inclination did not induce him to exceed the bounds of moderation in muscular activity.

Some of the medical gentlemen assembled at the autopsy were erroneously impressed with the opinion that the condition of the heart and aorta, as above described, was caused by rheumatism. The doctor did not fall a victim to that disease. Periosteal rheumatism causes calcareous deposits, exostosis, and anchylosis, and is not an ulcerative inflammation, a very severe and dangerous malady when it attacks the vertebral periosteum. Nor does rheumatism cause atrophy, or, more especially, the opposite states of atrophy and hypertrophy. A diseased action could not unite such opposite results.

The above case strikingly illustrates the fact of a force of motion, generated in the capillary circulation reciprocal with the heart's action. How this force of motion is generated is not the object of the present communication.

DOMESTIC SUMMARY.

Amputation at the Hip-joint.—Two very interesting cases of this operation, both successful, are reported (*New York Med. Journal*, Dec. 1876) by Dr. ERSKINE MASON. The first of these was a healthy lad, aged eighteen, who had paralysis of the right lower extremity following scarlet fever. This became complicated subsequently by a faulty mode of walking, etc., with extreme talipes equino-valgus. For the past five years he has been enabled to place the limb with his hands in various abnormal positions, and desired his limb removed as it was an incumbrance. On examination after admittance into Roosevelt Hospital, it was observed that as the patient lies upon his back, the right thigh lies "upon its outer surface, and at right angles to the pelvis. In this position the head of the femur can be felt to be near the ramus of the pubis. The leg is at right angles to the thigh, and cannot be extended, owing to a subluxation of the tibia outward. There is a paralysis of the extensor muscles of the leg and thigh, though some of the flexors and gluteal muscles are called into action. This limb is greatly atrophied.